

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11438 CERTIFICATE OF DEATH 11432

1. PLACE OF DEATH a. COUNTY <i>Harford Co.</i>		b. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b <i>3.0.4.</i>	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>849 Carroll St</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harford Memorial Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Rossie A. Boyd</i>		First <i>Rossie</i>	Middle <i>A.</i>
4. DATE OF DEATH <i>8-14-66</i>		Last <i>Boyd</i>	Month Day Year 8 - 14 1966
5. SEX <i>Male</i>		6. COLOR DR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>5-2-01</i>		9. AGE (In years last birthday) <i>65 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Federal</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>N.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richardus Boyd</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Watson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>17. INFORMANT</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>2 years 9 months</i>	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Obesity</i>		(b) <i>Arteriosclerotic Cardio Vascular Disease</i>	
DUE TO cause (a), stating the underlying cause last. <i>Diabetes Mellitus</i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8/27/66</i> to <i>8/14/66</i> , that (I) (we) last saw the deceased alive on <i>7/3/66</i> , and that death occurred at <i>111 M</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>8/15/66</i>	
22a. SIGNATURE <i>Walter Kohn</i>		22c. PHYSICIAN'S NAME (Type) <i>WALTER KOTHN</i>	22d. ADDRESS <i>102 E. Fort Ave.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-18-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>
24. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son Inc.</i>		ADDRESS <i>102 E. Fort Ave.</i>	25a. REC'D. BY REGISTRAR <i>AUG 16 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11439

## CERTIFICATE OF DEATH

11433

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harve de Grace</b> c. LENGTH OF STAY IN 1b <b>14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RISING SUN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		d. STREET ADDRESS <b>RDI - Post Road</b>	
3. NAME OF DECEASED (Type or print)	First <b>Gilbert</b>	Middle <b>Calvin</b>	Last <b>Campbell Sr.</b>
4. DATE OF DEATH	Month <b>August</b>	Day <b>21</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>2-16-1888</b> 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor Ret. Varsery</b>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>John B. Campbell</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CECIL Co. Md.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO. <b>915-16-6861</b>		17. INFORMANT <b>Mrs. Dorothy Al-RAMS</b> Address <b>Rising Sun, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> DUE TO <b>Complete Heart Block</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Stokes Adams Syndrome.</b> DUE TO <b>Generalized Arteric Sclerotic</b> (c) <b>Heart Disease</b>		1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Rising Sun</b> (County) <b>Harford Co.</b> (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 8</b> , 1966, to <b>Aug 21</b> , 1966 that (I) (we) last saw the deceased alive on <b>Aug 21</b> , 1966, and that death occurred at <b>3:59 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Ernest W. Seiter M.D.</b>		22b. DATE SIGNED <b>Aug 21, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ernest W. Seiter M.D.</b>		22d. ADDRESS <b>3 Wallace Ave., Harford Co., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-24-1966</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>CALVERT FRIENDS CEM.</b>		23d. LOCATION (City or Town) <b>CALVERT</b> (County) <b>CECIL</b> (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Lyndon B. Mullin</b>		25a. RECEIVED BY REGISTRAR <b>Charles Judge</b> AUG 24 1966	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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100-10200

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11440

## CERTIFICATE OF DEATH

11434

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY <i>Harford</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAURE de GRACE</i>		c. LENGTH OF STAY IN lb <i>3 days</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Cecil</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Conowingo</i>		d. STREET ADDRESS <i>R.F.D. #1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		07-2			
3. NAME OF DECEASED (Type or print) <i>William Pusey Carr</i>		First	Middle	Last	4. DATE OF DEATH <i>August 11 1966</i>	Month	Day	Year			
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-22-1880</i>	9. AGE (In years last birthday) <i>85 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. HRS. Hours <i>0</i>	13. MIN. Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>General</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Cecil Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Samuel Carr</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Shank</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>918-05-9403A</i>		17. INFORMANT <i>Ralph W. Carr</i>		Address <i>Conowingo Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500</i>		DUE TO <i>Armenia, B.P.H.</i>		INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Marked Cachexia + malnutrition</i>		(b) DUE TO <i>Generalized AS.</i>									
(c) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Harford</i>		(County) <i>Harford</i>		(State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>August 8, 1966</i> , to <i>August 11, 1966</i> , that (I) (we) last saw the deceased alive on <i>Aug. 8, 1966</i> , and that death occurred at <i>720 A.M.</i> from causes and on the date stated above.											
22a. SIGNATURE <i>P. K. Chan MD.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>7-11-66</i>					
22c. PHYSICIAN'S NAME (Type) <i>P. K. Chan MD.</i>		22d. ADDRESS <i>Harford Mem. Hosp.</i>									
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-13-66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Pleasant Grove</i>		23d. LOCATION (City or Town) <i>Peach Bottom L.A. Pa.</i>		(County) <i>Peach Bottom L.A. Pa.</i>		(State) <i>Pa.</i>	
24. FUNERAL DIRECTOR <i>Jemon McFadden</i>		ADDRESS <i>Rising Sun, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

11441 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 11435

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Harford</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FALLSTON</b>	c. LENGTH OF STAY IN lb <b>2 MOS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>412 STONEY TERRACE</b>	d. STREET ADDRESS <b>412 Stoney Terrace</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>JAMES TURNER</b>	First <b>CHASON</b>	Middle <b></b>	Last <b></b>	4. DATE OF DEATH <b>AUGUST 21 1966</b>	Month <b></b>	Doy <b></b>	Year <b></b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 27 1910</b>	9. AGE (In years last birthday) <b>56 yrs.</b>	IF UNDER 16 YEARS Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Air Condition Engineer</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>George R. Chason</b>			14. MOTHER'S MAIDEN NAME <b>Tinie Rau</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>215-03-1233</b>			17. INFORMANT <b>(WIFE) RUTH HILDA CHASON (SAME)</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b>			ACUTE CORONARY OCCLUSION						INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b>			DUE TO								
(c)			DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>Baltimore, Md.</b>	(County) <b></b>	(State) <b></b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Philip Heuman</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>AUG 21 1966</b>		
EXAMINER'S NAME (Type) <b>PHILIP W. HEUMAN, M.D.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						307 HICKORY AVE. BEL AIR, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/24/66.</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Cakowicz Cemetery</b>			22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Rick Inc 5-305 Harford Ave</i>		ADDRESS <i>1000 Harford Ave</i>		24a. REC'D BY REGISTRAR <b>AUG 25 1966</b>			24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

STATE 103

1960-1961

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

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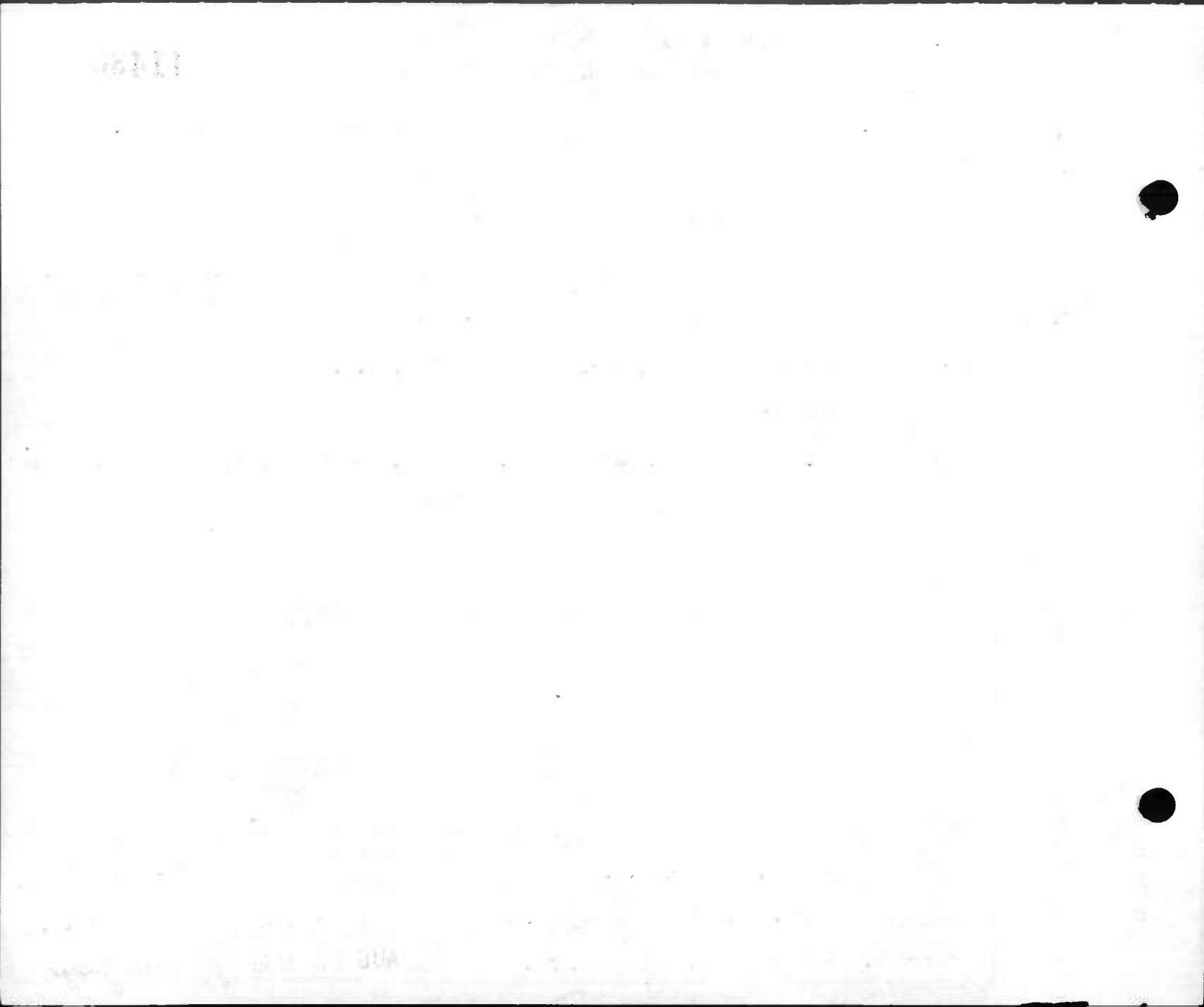
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11442

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11436

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN lb <b>Joppa</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		d. STREET ADDRESS <b>Clayton Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>GARNIE</b>	Middle <b>ISAAC</b>	4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>Oct. 28, 1912</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fork Lift Operator</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Ennisc, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Flemm Cockerham</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Evans</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-II 245-05-2084</b>	
17. INFORMANT <b>Mrs. Irene M. Cockerham, Clayton Road, Joppa</b>		Address <b>Md. Clayton Road, Joppa</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> INTERVAL BETWEEN ONSET AND DEATH 4201			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO stating the underlying cause (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald C. Palmer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 8/12/66	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Bel Air, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>Aug. 12, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Reins-Sturdivant</b>	23d. LOCATION (City or Town) (County) (State) <b>Sparta N.C.</b>
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>	ADDRESS	25a. RECEIVED BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>DATE AUG 15 1996</b>



1M  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in Item 18. Give copies to Item 2, and to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11443

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11437

1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Forest Hill

c. LENGTH OF STAY IN 1b

none

3. NAME OF  
DECEASED  
(Type or print)

First  
RAYMOND

Middle  
NMN

Last  
ELLER

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Sept. 1, 1952

9. AGE (In years  
last birthday)

13

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

12-1  
August 8

1966

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Harford Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Grant A. Eller

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank and dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Mr. Grant A. Eller, Rt.1, Box 49, Forest Hill, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

8254

DUE TO

Fracture 5 skull

INTERVAL BETWEEN  
ONSET AND DEATH

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying

(b)

DUE TO

Fracture L. femur

(c)

DUE TO

Fracture Canical Vertebra

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Autos accident

20c. TIME OF INJURY

Month, Day, Year

Hour

9:00 p.m.

5-8-66

19

20d. INJURY OCCURRED

Not Whila

at work

factory

street

office

bldg., etc.

20e. PLACE OF INJURY (Home, farm, 20f. (City or town)

(County)

(State)

Janesville Road Forest Hill Ha. Md.

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

Gerald C Palmer

CHIEF MEDICAL EXAMINER

BelAir, Md.

DATE SIGNED

EXAMINER'S  
NAME (Type)

Gerald C Palmer

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

8-9-66

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or country)

(State)

Burial

Aug. 11, 1966

BelAir Memorial Garden

BelAir

Md.

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Howard K. McComas & Son, Abingdon, Md. 21009

DATE AUG 11 1966 Charles Judge

VR A15ME  
5M 1/62



1  
M  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 4 Film G379 8/15/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11438

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill		c. LENGTH OF STAY IN lb 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RAYNARD NMM		First MIDDLE LAST	4. DATE OF DEATH Month Day Year August 8, 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1952
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 13 yrs.
13. FATHER'S NAME Grant A. Eller		11. BIRTHPLACE (State or foreign country) Harford Co., Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mr. Grant A. Eller, Rt. 1, Box 49, Forest Hill Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) last.		19. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident	
20c. TIME OF INJURY Month, Day, Year 950 a.m. 8-8 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Janetville Rd. Forest Hill Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 8-9-66	
ACTUAL SIGNATURE George C. Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air Md.	
EXAMINER'S NAME (Type) George C. Palmer - M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 11, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Cemetery
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md	
ADDRESS		25a. REC'D BY REGISTRAR AUG 11 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11445		CERTIFICATE OF DEATH						11439			
1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE de GRACE</b> c. LENGTH OF STAY IN lb <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD Memorial Hosp.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood Forest Hill (Rural)</b> d. STREET ADDRESS <b>Chestnut Hill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS <b>2018 STAR</b> 12-1							
3. NAME OF DECEASED (Type or print) <b>MARGARET</b> First <b>Virginia</b> Middle <b>England</b> Lost		4. DATE OF DEATH <b>August 11 1966</b>									
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 25, 1900</b>		9. AGE (In years lost birthday) <b>66 yrs.</b> IF UNDER 1 YEAR <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.					
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>			11. BIRTHPLACE (County & State, or foreign country) <b>ANNE ARUNDEL Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Smithson</b>			14. MOTHER'S MAIDEN NAME <b>Violet Scott</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) <b>—</b>			16. SOCIAL SECURITY NO. <b>218-52-3809</b>			17. INFORMANT (Son) <b>676-2690</b> Address <b>Mr. Willard M. England 2018 STAR Street Edgewood, Ind. 21040</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adrenal metastases &amp; insufficiency</b> DUE TO <b>Ca Breast.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Ca Breast.</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pathologic fracture right femur</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Pathologic fracture right femur</b>									
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. <b>—</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) <b>—</b> (County) <b>—</b> (State) <b>—</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>8/6 1966</b> to <b>8/11 1966</b> , that (I) (we) last saw the deceased alive on <b>8/11 1966</b> , and that death occurred at <b>925 M.</b> , fram causes and on the date stated above.											
22a. SIGNATURE <b>Dr. J. G. Scott</b>						22b. DATE SIGNED <b>8/11/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>AN. C. RIGOLEIT</b>		22d. ADDRESS <b>Haure de GRACE</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>August 13, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Deer Creek Methodist Ch. Cem.</b>			23d. LOCATION (City or Town) <b>Forest Hill</b> (County) <b>HARFORD Co.</b> (State) <b>MARYLAND</b>				
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
VR A15 (4) 20 M 1/66		DATE <b>AUG 15 1986</b>									

1900

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

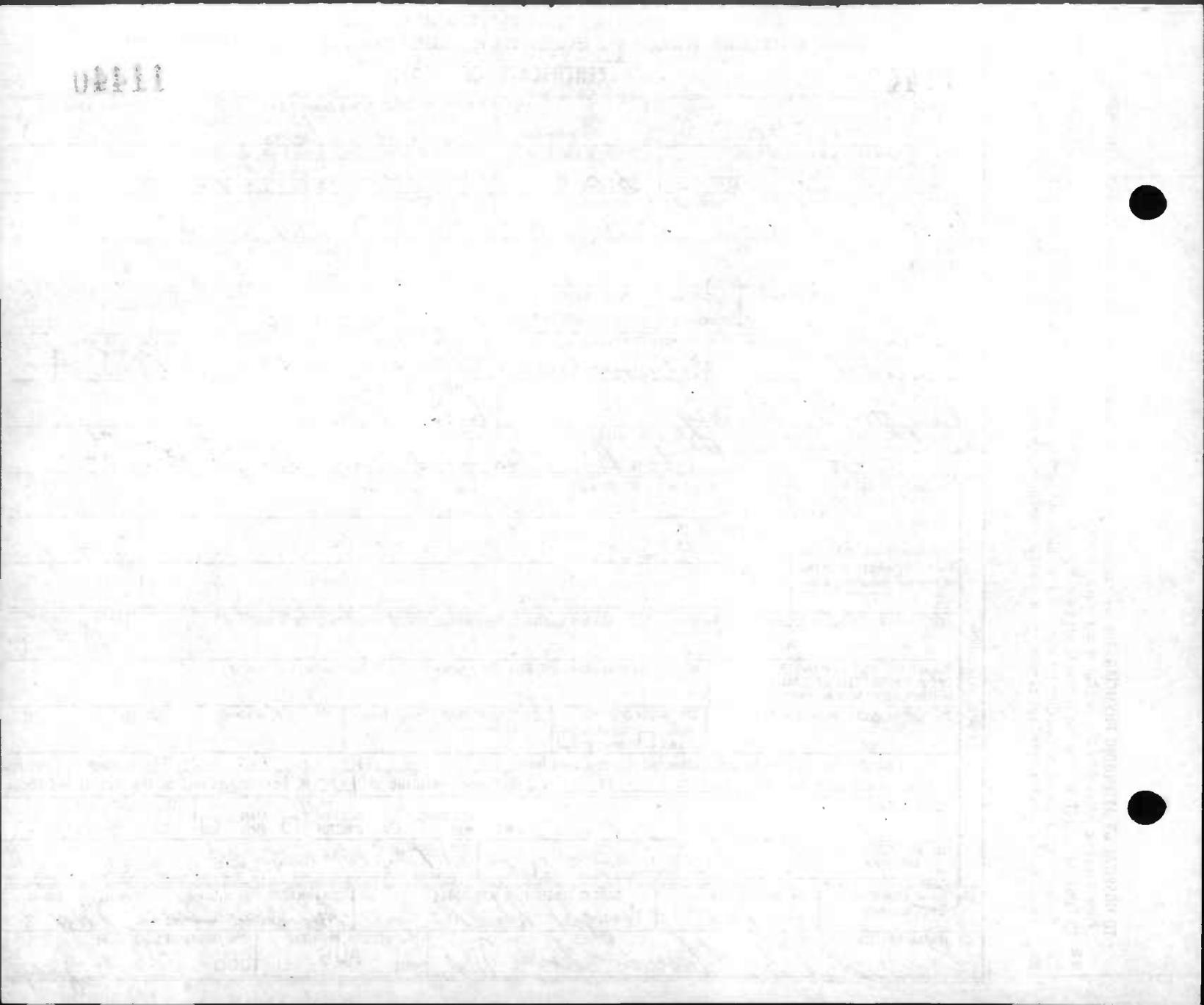
Item 7 Film G379 8/15/66 mn

## CERTIFICATE OF DEATH

11440

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11446		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE de Grace		c. LENGTH OF STAY IN 1b	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE de Grace 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		d. STREET ADDRESS 729 Ontario St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dorothy		First	Middle
4. DATE OF DEATH		Month	Day
5. SEX		6. COLOR OR RACE	7. MARRIED
Female white		WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Dots Hours Min.
5/21/1900		66 yrs.	11. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (County & State or foreign country) Edgewood Avenue, Haverde Grace	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Clifton Y. Keatley	
14. MOTHER'S MAIDEN NAME Lila Berlin		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 4201		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		19. INTERVAL BETWEEN ONSET AND DEATH (a) sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) A.S. C.V.D. + H.S.V.D. last. (c)		3-4 years	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenia, Chronic		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 P.M.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1966</u> to <u>Aug 4, 1966</u> that (I) (we) last saw the deceased alive on <u>8-4 1966</u> and that death occurred at <u>1751 Mt. from houses and an</u> the date stated above.		22b. DATE SIGNED 8/4/66	
22a. SIGNATURE Edward C. Loo, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/4/66
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22d. ADDRESS Haverde Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 8/6/66		23c. NAME OF CEMETERY OR CREMATORIAL Angel Hill	
23d. LOCATION (City or Town) (County) (State)		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
ADDRESS Pennsylvania Rd, Haverde Grace, Md.		DATE AUG 8 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11441

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS <b>414 Parke Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>414 Parke Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>FRED</b>	Middle	Last <b>FINE</b>
4. DATE OF DEATH	Month <b>August</b>	Year <b>1966</b>	Day <b>15</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1908</b>
9. AGE (In years last birthday) <b>57</b> yrs.	10. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt. APG</b>	11. BIRTHPLACE (State or foreign country) <b>Kiev, Russia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>David Fine (D)</b>	14. MOTHER'S MAIDEN NAME <b>Rebecca Schneider (D)</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> WW-2	16. SOCIAL SECURITY NO. <b>505-10-2458</b>	17. INFORMANT <b>Jack Fine, Pittsburgh, Penna.</b>	18. ADDRESS <b>2444 Park Hill Drive</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-venous cv disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
22. ACTUAL SIGNATURE <b>Gerald C. Palmer</b>		23. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
24. EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>		25. DATE THEREOF <b>8-18-66</b>	
26. FUNERAL DIRECTOR <b>J. Tarrin</b>		27. ADDRESS <b>Tarrin Funeral Home, Aberdeen, Md.</b>	
28. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		29. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery, Arlington, Va.</b>	
30. LOCATION (City or Town) (County) (State) <b>Bel Air, Md.</b>		31. REC'D BY REGISTRAR <b>AUG 18 1966</b>	
32. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11448

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11442

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "Pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen (Rural)</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route #1</b>		d. STREET ADDRESS <b>Route #1, Box 259</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1966</b>	
3. NAME OF DECEASED (Type or print) <b>First CARROLL Middle WALLACE Last GILBERT</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1966</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Sept 1890</b> 9. AGE (In years last birthday) yrs. <b>75</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civilian Gunner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt. APG.</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Gilbert</b>		14. MOTHER'S MAIDEN NAME <b>Kate Savor</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>*** *** ***</b>	
17. INFORMANT <b>Mrs. Floyd MaHan, Aberdeen, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic C V Disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Bel Air, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-6-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Smith Chapel Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Aberdeen, Maryland</b>		23e. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>John H. Tanning</i>		25a. ADDRESS Tanning Funeral Home Aberdeen, Md.	
25b. REGISTRAR'S SIGNATURE DATE AUG 8 1966 <i>Charles Judge</i>		25c. REC'D BY REGISTRAR	

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FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11449 11443

1. PLACE OF DEATH a. COUNTY <i>Hanford</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>nd</i> b. COUNTY <i>Hanford</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>20A Hanford Memorial Hospital Swan Harbor Del Norte Ct</i>			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Florence K. Hodges</i>	First	Middle	Last	4. DATE OF DEATH <i>August 2 1966</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 22, 1938-28</i>	9. AGE (In years last birthday) <i>28 yrs.</i> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>		
11. BIRTHPLACE (State or foreign country) <i>Independence, Va.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Rance Billings D.</i>			14. MOTHER'S MAIDEN NAME <i>Zollie Osborne</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>REIN Noah Dolinger, Havre de Grace, Md</i>		
17. INFORMANT <i>REIN Noah Dolinger, Havre de Grace, Md</i>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia due to Drowning</i>			INTERVAL BETWEEN ONSET AND DEATH		
9298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Drowned in Pool</i>		
20c. TIME OF INJURY Month, Day, Year Hour <i>8</i> p.m. 8-2 66 p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/> <i>Pool</i>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Aberdeen Han Md</i>			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Rein Noah Dolinger</i>		
ACTUAL SIGNATURE <i>Gerald C Palmer</i>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>2011</i>		
22. DATE SIGNED <i>8-3-66</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>			23b. DATE THEREOF <i>4 Aug. 66</i>		
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Pleasant Grove Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Independence, Va.</i>		
24. FUNERAL DIRECTOR <i>Tarring Funeral Home</i>			25a. REC'D BY REGISTRAR <i>25b. REGISTRAR'S SIGNATURE</i>		
ADDRESS <i>Aberdeen, Md.</i>			DATE <i>AUG 5 1966</i> <i>Charles Judge</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11444

11450

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove at bottom papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hanape-de-Grace</b> 12 days		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b> 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		d. STREET ADDRESS <b>73 Swann St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH 8/21/66	
3. NAME OF DECEASED (Type or print)	First <b>George</b>	Middle <b>Clark</b>	Last <b>Hoffmann</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC-17-1910</b>
9. AGE (In years last birthday) <b>55</b>	10. IF UNDER 1 YEAR Months <b>8</b> Days <b>4</b>	11. IF UNDER 24 HRS. Hours <b>4</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Cutters</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Hubert Hoffmann</b>	14. MOTHER'S M AIDEN NAME <b>Flossie Clark</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>213-07-9527</b>	17. INFORMANT <b>Herbert H. Hoffman</b>	18. ADDRESS <b>6500 Colgate Ave.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5810 Hepatic Coma</b>			19. INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Portal Cirrhosis &amp; Portal Hypertension</b>			
DUE TO (b) <b>Portal Cirrhosis &amp; Portal Hypertension</b>			
DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gastrointestinal Hemorrhage; Bronchopneumia</b>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that (I) (this hospital) attended the deceased from <b>8-9</b> , 19 <b>66</b> , to <b>8-21</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>8-21</b> , 19 <b>66</b> , and that death occurred at <b>4357</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>W.H. Sadowsky</b>		22b. DATE SIGNED <b>8/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.H. Sadowsky</b>	22d. ADDRESS <b>504 Lewis St. Hanover</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8/24/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>ROCKELAND</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. Co. MD</b>
24. FUNERAL DIRECTOR <b>Brock Bradley Funeral Home, Balt. Md.</b>	25a. ADDRESS <b></b>	25b. REC'D BY REGISTRAR <b></b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11451

## CERTIFICATE OF DEATH

11445

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE de GRACE</b>		c. LENGTH OF STAY IN 1b <b>7 hrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD Memorial Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jerry</b>		First <b>Jerry</b>	Middle <b>Wayne</b>
Last <b>Holcomb</b>		4. DATE OF DEATH Month <b>AUGUST</b>	Day Year <b>15 1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 15, 1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Harford</b>		12. CITIZEN OF WHAT COUNTRY? <b>Md</b>	
13. FATHER'S NAME <b>Robert William Holcomb</b>		14. MOTHER'S MAIDEN NAME <b>Patsy Wykse</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Robert W. Holcomb, 1406-B Willow Oak Rd.</b>		Address <b>Edgewood, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>724X</b> <i>Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <b>(Congenital defect?)</b> (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>8/15 1966</b>
20f. (City or town) <b>8/15 1966</b>		(County) (State) <b>8/15 1966</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>8/15 1966</b> to <b>8/15 1966</b> , that (I) (we) last saw the deceased alive on <b>8/15 1966</b> and that death occurred at <b>925</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>J. Hatem</b>		22b. DATE SIGNED <b>8/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. J. Hatem, M.D.</b>		22d. ADDRESS <b>Harve de Grace, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 16, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Zion Cemetery</b>
23d. LOCATION (City or Town) <b>Bel Air</b>		(County) (State) <b>Harford Md</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md. 21009</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 19 1966</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11452

CERTIFICATE OF DEATH

11446

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		a. STATE		b. COUNTY	
Harford		Harford		MARYLAND		Md		Baltimore		Colgate	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Harford Mem. General Hosp.		500 North Point Rd		03-2		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
JOHN		C.	Klemm		Aug. 8th			1966			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. FUNDER 1 YEAR	11. FUNDER 24 HRS			
Male		White			Feb. 19-1898	68 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Plumber			self Emp.			Germany			U. S. A.		
13. FATHER'S NAME		May J. J. Klemm		14. MOTHER'S MAIDEN NAME		Meta					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
(Yes, no, or unknown)		215-01-95579		Howard Klemm - same as above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>											
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arterio Sclerosis</u> ? DUE TO (c) <u>Heart Block</u> 5 yrs DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY		Month, Day, Year	Hour a.m.	White	Not White	at work	at work				
			p.m.	19							
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10, 1966</u> , to <u>Aug 8, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug 7, 1966</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE		22b. DATE SIGNED									
Joseph Pekorny		8/10/66									
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		M.D. ATTENDING PHYS.		M.D. DIRECTOR		STAFF PHYS.		8/10/66	
Dr. Joseph POKORNY		2200 E Madison St		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)			
Burial		Aug. 12-66		Oak Lawn Cemetery		Baltimore		Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Connally Funeral Home - 300 Main Ave.				DATE AUG 12 1966		Charles Judge					

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11453

## CERTIFICATE OF DEATH

11447

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hardey Grace</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17+2 - Box 104 Aberdeen</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Brevia Nursing Home</i>		d. STREET ADDRESS <i>Bel Air Road 12-1</i>	
3. NAME OF DECEASED (Type or print) <i>Jacob</i>		First <i>—</i>	Middle <i>—</i>
4. DATE OF DEATH <i>8 23 1966</i>		Month <i>8</i>	Day <i>23</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH <i>9/28/1873</i>		9. AGE (In years last birthday) <i>92 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Germany</i>
13. FATHER'S NAME <i>John Brown</i>		14. MOTHER'S MAIDEN NAME <i>Un Brown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Samuel J. Woods - Box 104 - 17+2</i>		Address <i>Shruberry Blvd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>			
332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral &amp; generalized arteriosclerosis</i> 10+ yrs (c) <i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Thrombus R. posterior artery bronchopneumonia</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>5/19/66</i> , 19, to <i>8/23/66</i> , 19, that (I) (we) last saw the deceased alive on <i>8/23/66</i> , 19, and that death occurred at <i>4:45 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>B. J. Plunkett Jr.</i>		22b. DATE SIGNED <i>8/24/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Barry J. Plunkett, Jr.</i>		22d. ADDRESS <i>Aberdeen Harford Co. Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/26/1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bakers Cemetery</i>
23d. LOCATION (City or Town) (County) (State)		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Tanning Funeral Home</i>		ADDRESS <i>1000 Aberdeen Rd.</i>	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	
DATE <i>AUG 26 1966</i>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, at any event within 72 hours of death.

11454

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11448

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Harford MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill		b. COUNTY Harford	
c. LENGTH OF STAY IN 1b 11 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md 24		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle
Leroy		Litt	jeton
4. DATE OF DEATH		Month	Year
August 6		Day	Year 1966
5. SEX		6. COLOR OR RACE	7. MARRIED NEVER MARRIED WIDOWED DIVORCED
M		W	Separated
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer		Construction	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Powellville, Md		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Lee Roy Littleton		Maggie Mae Dennis.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wdr or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT Lee Roy Littleton, Fawn Grove, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8254		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)	
		DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Auto Accident	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:50 p.m. 8-6 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Md St 24		20f. (City or town) (County) (State) Forest Hill Hs. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 8-6-66	
ACTUAL SIGNATURE Gerald C Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Robert, M.D.	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 8-6-66	
23a. BURIAL, CREMATION, REMOVAL Specify Burial		23b. DATE THEREOF 8-9-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) (County) (State) New Hope Meth. Cemetery, Williams, Wicomico Co, Md.	
24. FUNERAL DIRECTOR Jacqueline L. Palmer, New Freedom, Pa.		25a. REC'D BY REGISTRAR Charles Judge	
		25b. REGISTRAR'S SIGNATURE	

6111

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11449

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<p style="text-align: center;">11455</p> <p>1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b> c. LENGTH OF STAY IN lb <b>1 hr. 14 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kirk Army Hospital</b></p>		<p>2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen, Maryland</b> d. STREET ADDRESS <b>166 Allendale Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <b>Joseph</b> First <b>INFANT MALE, MARCKINI</b> Middle Last</p>		<p>4. DATE OF DEATH <b>Aug 10 1966</b></p>	
<p>5. SEX <b>M</b> 6. COLOR OR RACE <b>Mong-Cau</b></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>10 Aug 66</b></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b></p>	
<p>13. FATHER'S NAME <b>MARCKINI, Richard</b></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Harford, Maryland</b></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>N/A</b></p>	
<p>17. INFORMANT <b>Richard Marckini, Aberdeen, Md.</b></p>		<p>Address</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p>		<p>INTERVAL BETWEEN ONSET AND DEATH <b>From Birth</b></p>	
<p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b></p>		<p>DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <b>7593</b></p>	
<p>(b) <b>Suspected multiple congenital anomalies</b></p>		<p>DUE TO <b>From Birth</b></p>	
<p>(c)</p>		<p></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <b>10 Aug 66</b> to <b>10 Aug 66</b> that (I) (we) last saw the deceased alive on <b>10 Aug 66</b> 19 <b>66</b>, and that death occurred at <b>0720M</b> from the causes and on the date stated above.</p>		<p>22b. DATE SIGNED <b>10 Aug 66</b></p>	
<p>22a. SIGNATURE <b>Leland R. Wight</b></p>		<p>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>	
<p>22c. PHYSICIAN'S NAME (Type) <b>LELAND WIGHT, CPT., MC</b></p>		<p>22d. ADDRESS <b>Kirk Army Hospital, APG, Md.</b></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>23b. DATE THEREOF <b>8-12-66</b></p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Post Cemetery</b></p>		<p>23d. LOCATION (City, town or county) (State) <b>Aberdeen Proving Ground</b></p>	
<p>24. FUNERAL DIRECTOR <b>Jaming Funeral Home</b></p>		<p>25a. REC'D BY REGISTRAR DATE <b>AUG 15 1966</b></p>	
<p>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b></p>			



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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11450

1455

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Harford		MARYLAND Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 5 hrs.	
Havre-de-Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Harford Memorial Hospital		d. STREET ADDRESS 915 Elizabeth St	
66		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Aug 22, 1966	
Robert Thomas Mason		First	Middle
Last		Month	Day
5. SEX		6. COLOR OR RACE	7. MARRIED
Male		Negro	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH May 1, 1908	
Cook		9. AGE (In years last birthday) 58 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Gov.		11. BIRTHPLACE (County & State, or foreign country) Alabama	
13. FATHER'S NAME Crawford Thomas Mason		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 212-38-0589	
17. INFORMANT Mrs. Brenda H. Mason - Home Owner		Address 915 Elizabeth St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } (c) }		DUE TO Stomach with large and cerebral metastases	
DUE TO		2 MRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June, 1965, to 8/22, 1966, that (I) (we) last saw the deceased alive on 8/22, 1966, and that death occurred at 3:30 P.M., from causes and on the date stated above.			
22a. SIGNATURE W.H. Sadowsky		22b. DATE SIGNED 8/22/66	
22c. PHYSICIAN'S NAME (Type) W.H. SADOWSKY		22d. ADDRESS 504 Lewis St. Havre-de-Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 25, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Otelia J. Bullock, Havre-de-Grace, Md.		25a. RECEIVED BY REGISTRAR DATE AUG 29 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11457

11451

10. HOSPITAL OR ATTENDING PHYSICIAN:		The law requires that the death certificate be executed within 24 hours after death.													
Page 4 may be retained by the hospital or attending physician.															
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.															
1. PLACE OF DEATH a. COUNTY		Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		a. STATE		Maryland		b. COUNTY		Harford	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Havre de Grace		25 yrs.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Havre de Grace		12-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		328 Wilson Street				d. STREET ADDRESS		328 Wilson St.				e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First George		Middle W.		Last Owens		4. DATE OF DEATH		Month Aug.		Day 1		Year 1966	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years at last birthday)		10. UNDER 1 YEAR		11. UNDER 24 HRS.			
Male		Negro		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb. 2, 1879		81 yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Handy man		Garage		Annapolis, Md.		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
Thomas Owens		Mary (no Record)													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
No		218-07-2208A		Mrs. Agnes Boddy		1987, Main St., Port Deposit, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO													
610X		Urinary Retention													
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO													
		Benign Prostatic Hypertrophy													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
White at work <input type="checkbox"/>		Not White at work <input type="checkbox"/>													
21. I certify that (I) (this hospital) attended the deceased from 6/2, 1966, to 8/1, 1966, that (I) (we) last saw the deceased alive on 7/30, 1966, and that death occurred at 12:45 PM, from the causes and on the date stated above.															
22a. SIGNATURE		22b. DATE SIGNED													
George T. Stansbury, M.D.		8/3/66													
22c. PHYSICIAN'S NAME (Type)		George T. Stansbury		22d. ADDRESS		569 Revelation St, Havre de Grace, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)							
Burial Aug. 6, 1966				Jones Cemetery		Cokesbury, Cecil Co.		Md.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Otelia J. Bullock, Havre de Grace, Md.															
				DATE AUG 5 1966		j Charles Judge									



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

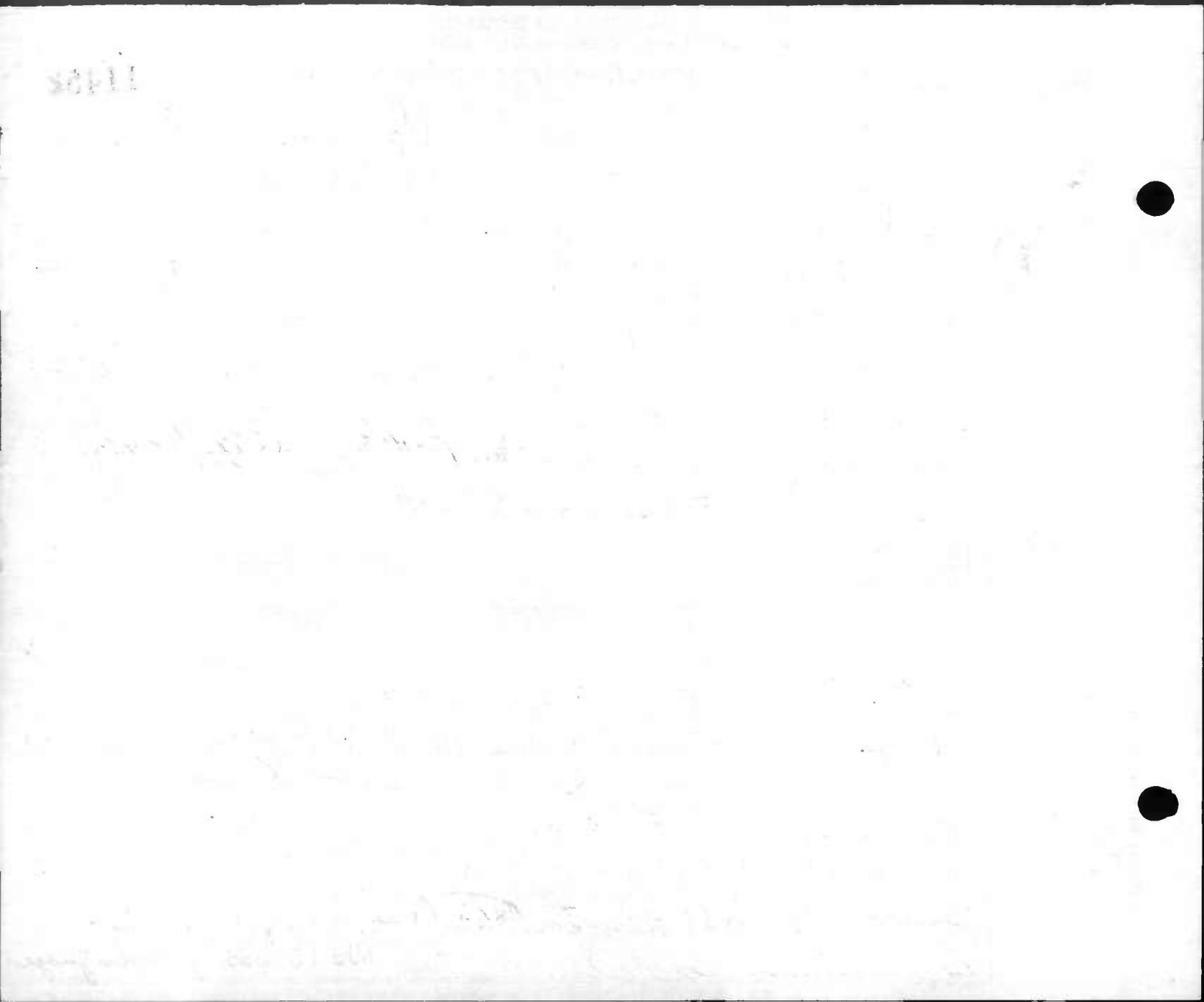
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11458

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11458

1. PLACE OF DEATH a. COUNTY <i>#27-for d</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Hanford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Asbury-de Grace</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>DOA Harrison Memorial Hosp 124 New County Rd</i>		d. STREET ADDRESS <i>12-1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John E. Ree</i>		First	Middle
4. DATE OF DEATH <i>August 7 1966</i>	Month	Day	Year
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <i>5 Feb 36</i>
9. AGE (In years lost birthday) yrs. <i>30</i>	10. IF UNDER 1 YEAR Months <i>19</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Soldier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>US Army</i>	
11. BIRTHPLACE (State or foreign country) <i>Honolulu, Hawaii</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Herbert W. Ree</i>		14. MOTHER'S MAIDEN NAME <i>Sylvia Dorothy Keers</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>7/1/53</i>		16. SOCIAL SECURITY NO. <i>101-28-1434</i>	
17. INFORMANT <i>Mrs. Betty Ree, Aberdeen, Md.</i>		18. ADDRESS <i>124 New County Rd.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <i>8-7-66</i>	
21. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>FY factu, c SKu 11</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
23. MEDICAL CERTIFICATION PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		24. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
25. TIME OF INJURY Month, Day, Year Hour a.m. <i>8-7-66</i>		26. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Maynard Rd</i>
28. (City or town) <i>Aberdeen + a mt</i>		(County) (State)	
29. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
30. ACTUAL SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S (Type) <i>Gerald C Palmer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
31. EXAMINER'S (Type) <i>Gerald C Palmer</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
32. ADDRESS (Street, city, town, or county) <i>Bel Air, Md</i>			
33. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		34. DATE THEREOF <i>8/11/1966</i>	35. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National Cemetery</i>
36. LOCATION (City or Town) <i>Arlington, Va.</i>		(County) (State)	
37. FUNERAL DIRECTOR <i>Lee G. Palmer Jr., Perryville, Md.</i>		38. ADDRESS <i>Lee G. Palmer Jr., Perryville, Md.</i>	39. REC'D BY REGISTRAR <i>AUG 15 1966</i>
40. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		41. DATE <i>8-7-66</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11453

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>	c. LENGTH OF STAY IN 1b <i>37 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>	d. STREET ADDRESS <i>P.O. Box 265</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>James</i>	Middle <i>Hunter</i>	4. DATE OF DEATH Month <i>August 18</i> Year <i>1966</i>
5. SEX <i>Male</i>	6. CCLDR OR RACE <i>White</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> SEP DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 2, 1935</i>
9. AGE (In years last birthday) yrs. <i>38</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Debt Collector</i>	11. KIND OF BUSINESS OR INDUSTRY <i>V.A. Ferry Point</i>	12. BIRTHPLACE (County & State, or foreign country) <i>LEEDS, ENGLAND</i>
13. FATHER'S NAME <i>EDGAR S. SHARER</i>	14. MOTHER'S MAIDEN NAME <i>LEODA E. CRAWFORD</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>YES MARINES</i>	
16. SOCIAL SECURITY NO. <i>212-32-7904</i>		17. INFORMANT <i>Mr. LEO DA E. SHARER, Havre de Grace, Md.</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4344</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Etiology was not determined.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>Diabetes mellitus, Bronchial Asthma, Obesity</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> refused	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>injury</i>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <i>CUMBERLAND MD</i>
21. I certify that (I) (this hospital) attended the deceased from <i>7-13, 1966</i> , to <i>8-18, 1966</i> that (I) (we) last saw the deceased alive on <i>8-18, 1966</i> and that death occurred at <i>239A M</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Edward C. Loo</i>	22b. DATE SIGNED <i>8/18/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>	22d. ADDRESS <i>Havre de Grace, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>Aug. 20, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>ROSE HILL</i>	23d. LOCATION (City or Town) (County) (State) <i>CUMBERLAND MD</i>
24. FUNERAL DIRECTOR <i>R. Madison Mitchell, HAVRE DE GRACE, MD.</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>AUG 22 1966</i>	25b. REGISTRAR'S SIGNATURE <i>John C. Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11454

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11460		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		a. STATE Pa.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE de Grace, Md.		b. COUNTY Bucks	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Levittown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		d. STREET ADDRESS 7 Willow Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		75-3	
3. NAME OF DECEASED (Type or print) Louis		4. DATE OF DEATH	Month Aug. 14 Year 1966
First Male	Middle white	Lost Smith	Doy 14
6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/1908	9. AGE (In years) 58 lost birthday yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant	10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTH PLACE (County & State, or foreign country) Brooklyn, N.Y.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Unknown	14. MOTHER'S MARRIED NAME Unknown	Address Willow Drive, Levittown, Pa.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 052-10-3667	17. INFORMANT Ann Smith	INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Thrombosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on Aug. 14 1966, and that death occurred at 1115 M, from causes and on the date stated above.			
22a. SIGNATURE Norman Berger		22b. DATE SIGNED 8-14-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS HAURE de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/18/66	23c. NAME OF CEMETERY OR CREMATORIAL King David
23d. LOCATION (City or Town) (County) (State)		Oakford Pa.	
24. FUNERAL DIRECTOR		ADDRESS	
Orrin Murphy, Son, Haure de Grace, Md.		25a. REC'D. BY REGISTRAR AUG 17 1966 DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

40211

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11461

## CERTIFICATE OF DEATH

11455

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE de GRACE		c. LENGTH OF STAY IN lb 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARION	Middle Rubbican	Last Smith
4. DATE OF DEATH	Month Aug	Day 19	Year 1966
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 26, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY HOUSE PAINTER	
11. BIRTHPLACE (County & State, or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WM E. SMITH		14. MOTHER'S MAIDEN NAME MARGARET OLIVE SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 269-12-8267	
17. INFORMANT Mrs. Margaret G. Smith HAVRE DE GRACE, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5705 DUE TO <i>Ch. lab. Bronchopneumonia</i> INTERVAL BETWEEN ONSET AND DEATH 5 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Intestinal Obstruction</i> 11 days (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Sec. Anemia, Ch. Emphysema, Ch. Ht. Failure</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on Aug. 19 1966, and that death occurred at 455 M, fram causes and on the date stated above.			
22a. SIGNATURE <i>W.H. Sadowsky</i>		22b. DATE SIGNED 8/19/66	
22c. PHYSICIAN'S NAME (Type) <i>W.H. SADOWSKY</i>		22d. ADDRESS 504 Lewis St., Havre de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug. 22, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL CRESTVIEW		23d. LOCATION (City or Town) (County) (State) BARNESVILLE OHIO	
24. FUNERAL DIRECTOR ADDRESS <i>P. Madeline Mitchell, Havre de Grace, Md.</i>		25a. REC'D BY REGISTRAR DATE AUG 22 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11456

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		
Harford MARYLAND		Md Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Harde-Grace 40 days		BEL AIR, 12-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		
Harford Memorial Hospital		RD#2		
e. NAME OF DECEASED (Type or print)		First	Middle	
Fannie Christy STERRETT		Lost	4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	7. MARRIED	
Female Negro		WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH		
10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years (In months, days, & birthday) yrs.		
10c. FATHER'S NAME		11. BIRTHPLACE (County & State, or foreign country)		
William Thomas		12. CITIZEN OF WHAT COUNTRY?		
13. MOTHER'S MAIDEN NAME		Mary BARRETT USA		
14. ADDRESS		15. SOCIAL SECURITY NO.		
16. INFORMANT		17. Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), (b) Arteriosclerotic CV Disease stating the underlying cause last. (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. P.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-2, 1966, to 8-6, 1966, that (I) (we) last saw the deceased alive on 19, and that death occurred at 9:29 PM, from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE CHAN MD		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) P. K. CHAN M.D.		22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-11-66	23c. NAME OF CEMETERY OR CREMATORIAL Asbury Cemetery	23d. LOCATION (City or Town) (County) (State) Bel Air Har Md
24. FUNERAL DIRECTOR George W. Tittle		ADDRESS Bel Air md	25a. REC'D BY REGISTRAR DATE AUG 12 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11463

## CERTIFICATE OF DEATH

11457

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE					
Harford Maryland		Md.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Harre-de-Grace					
Harre-de-Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre-de-Grace					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Harford Memorial Hospital R. D#1, Box 122					
3. NAME OF DECEASED (Type or print)		First	Middle				
Emily L.			Timms				
4. DATE OF DEATH		Month	Day Year				
5 24 1966							
5. SEX		6. COLOR, OR RACE	7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
Female		White	<input checked="" type="checkbox"/>	10/81 1899			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
Unemployed		Home		Tenn.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Unknown		Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS George W Timms - Box 124 RT#1	
No		213-52-7715					
19. MEDICAL CERTIFICATION		IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH	
4201		DUE TO Congestive Heart Failure					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO Generalized A.S.; ASHD.					
(c)							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		Diabetes Mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that (I) (this hospital) attended the deceased from 8-21-66, 19 to 8-24, 1966 that (I) (we) last saw the deceased alive on 8-24 1966, and that death occurred at 332A M, from causes and on the date stated above.							
22a. SIGNATURE		George J. Dendrinos M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/26/66
22c. PHYSICIAN'S NAME (Type)		GEORGE J. DENDRINOS M.D.		22d. ADDRESS EDGEWOOD Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/27/1966		23c. NAME OF CEMETERY OR CREMATORIAL Grove Cemetery		23d. LOCATION (City or Town) Aberdeen, Harford Co. Md.	
Burial							
24. FUNERAL DIRECTOR		ADDRESS Walter McCormick Jr. Fahey Funeral Home, Aberdeen		25a. REC'D BY REGISTRAR AUG 29 1966		25b. REGISTRAR'S SIGNATURE Charles J. George	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8,9 Film G380 8/29/66 mh

## CERTIFICATE OF DEATH

11464 11450

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hause de Grace</i>		c. LENGTH OF STAY IN 16 <i>40 days</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BELAIR</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>740 Moore's Mill Rd</i>	
3. NAME OF DECEASED (Type or print)	First <i>CLARENCE</i>	Middle <i>WINFIELD</i>	4. DATE OF DEATH Month Day Year <i>WALKER August 18 1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <i>April 4, 1889</i>
9. AGE (In years last birthday) <i>77 yrs.</i>	10. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Md (Harford Co.)</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	13. FATHER'S NAME <i>Abraham Baldwin Walker</i>		
14. MOTHER'S MAIDEN NAME <i>Mary ELLEN Brookhart</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		
16. SOCIAL SECURITY NO. <i>212-32-3267</i>	17. INFORMANT (with) <i>838-3298</i> Address Mrs. MINNIE M. WALKER <i>740 Moore's Mill Rd.</i> Bel Air Maryland 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
443 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive and Arteriosclerotic</i> (c) <i>Cardiovascular Disease</i>			3-4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)
20f. (City or town) <i>Harford</i> (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>Aug 15, 1966</i> to <i>Aug 18, 1966</i> that (I) (we) last saw the deceased alive on <i>Aug 18, 1966</i> , and that death occurred at <i>755 A</i> M, from causes and on the date stated above.	
22a. SIGNATURE <i>Edward C. Loo</i>		22b. DATE SIGNED <i>8/18/66</i>	22c. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>August 20, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Zion Methodist Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Fountain Green Harford Co., Md.</i>
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>		ADDRESS <i>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</i>	25a. REC'D. BY REGISTRAR DATE <i>AUG 22 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11465

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		d. STREET ADDRESS <b>712 Green St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Arthur</b>	Middle <b>J.</b>	Last <b>Way</b>	4. DATE OF DEATH Month <b>August</b>	Day <b>23</b>	Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <b>10/24/1895</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months <b>7</b>	IF UNDER 24 HRS. Days <b>2</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DISABLED AMERICAN VET</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.A.V.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Town Point, Cecil, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANDREW JOHNSON Way</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE MCKENNA</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WWI NONE</b>		17. INFORMANT <b>Mrs Arthur Way</b>		Address <b>712 Green St. Harford, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 da</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) and (c) <b>6000</b>		DUE TO (b) <b>Chronic pyelonephritis</b>				> 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma Rectosigmoid</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) <b>Havre de Grace</b>	(County) <b>Md</b>
21. I certify that (I) (this hospital) attended the deceased from <b>8-13 1966</b> to <b>8-23 1966</b> that (I) (we) last saw the deceased alive on <b>8-23 1966</b> , and that death occurred at <b>10:30 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Charles Grigoleit</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/23/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. W. GRIGOLEIT</b>		22d. ADDRESS <b>Havre de Grace Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/24/1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>ANGEL Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>HAVRE DE GRACE Md</b>	
24. FUNERAL DIRECTOR <b>Bennett &amp; Son</b>		ADDRESS <b>Havre de Grace Md</b>		25a. REC'D BY REGISTRAR <b>AUG 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

Page

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

11466

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence at time of admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE MD</b>		c. LENGTH OF STAY IN 1b <b>2 YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WILLIS BOARDING HOUSE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>VIOLA</b>	Middle <b>MARIE</b>	Last <b>WILLIS</b>
4. DATE OF DEATH Month <b>AUG.</b> Day <b>31</b> Year <b>1966</b>	5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>SEPT 15, 1918</b>	9. AGE (in years last birth day) <b>47 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOARDING HOME</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>SAME</b>
11. BIRTHPLACE (County & State, or foreign country) <b>LEE CO. VA.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>JOHN EMMORY WILLIS</b>	14. MOTHER'S MAIDEN NAME <b>NETTIE CLAUSON</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>UNK</b>	17. INFORMANT <b>MRS. ADDIE MAE BALDWIN</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)  180 X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.  (b)  (c)		1 month.	
DUE TO  180 X  (b)  (c)		Approx 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, lerm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 15th 1966</b> to <b>Aug. 31, 1966</b> that (I) (we) last saw the deceased alive on <b>Aug. 31st 1966</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE  <i>Edward C. Loo</i>		22b. DATE SIGNED <b>8/31/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward C. Loo, MD</b>		22d. ADDRESS <b>Haure de Grace, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/2/1966</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>BAPTIST VIEW</b>		23d. LOCATION (City, town or county) (State) <b>FORREST HILL MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE  <i>Pennington + Son, Haure de Grace, Md.</i>		25a. REGISTERED REGISTRAR DATE <b>SEP 6 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>quarter judge</b>	

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